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Convention on the Elimination of All Forms of Discrimination against Women

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Committee on the Elimination of Discrimination against Women
Twenty-sixth session
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Item 6 of the provisional agenda*
Implementation of article 22 of the Convention on the Elimination of All Forms of Discrimination against Women

Reports provided by specialized agencies of the United Nations on the implementation of the Convention in areas falling within the scope of their activities

Note by the Secretary-General

Addendum

World Health Organization

1. On behalf of the Committee, on 30 October 2001 the Secretariat invited the World Health Organization (WHO) to submit to the Committee a report on information provided by States to WHO on the implementation of the Convention on the Elimination of All Forms of Discrimination against Women, in areas falling within the scope of its activities, which would supplement the information contained in the reports of the States parties to the Convention that will be considered at the twenty-sixth session of the Committee.

2. Other information sought by the Committee refers to activities, programmes and policy decisions undertaken by WHO to promote the implementation of the Convention.

3. The report annexed hereto has been submitted pursuant to the Committee's request.

* CEDAW/C/2002/I/1.

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Annex

Report of the World Health Organization to the twenty-sixth session of the Committee on the Elimination of Discrimination against Women

Comments on the health of women in Fiji

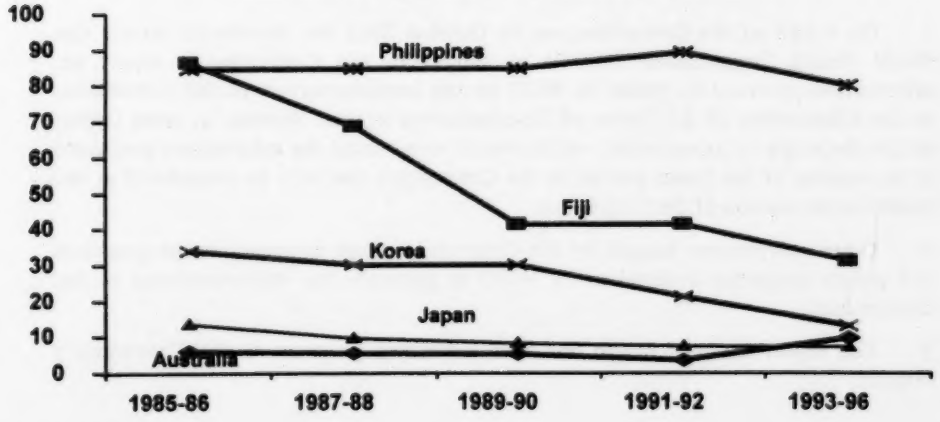
Fiji is a comparatively small, island nation in the South Western Pacific. The total population is 817,000 (402,000 women and 415,000 men)[1]. Roughly 1/3 of the people (31%)[2] are below the age of 15. The overall population growth rate is only 1.2% per year[3]. The urban growth rate is 2.9% per year[4]. The country is ranked lower-middle income level in World Bank reports[5] However, 25% of the population still live below the poverty line[6].

The general health situation in Fiji shows significant improvement during the last decade with steady progress being made toward control of infectious diseases such as Tuberculosis and measles. Likewise, there have been significant reductions in infant and child mortality rates (IMR and CMR(*)) :

	1960[7]	1998-99[8]
IMR	71	17.8
CMR	97	22

Fiji's work on **maternal mortality** has been effective. Maternal mortality ratios (MMR)(+) declined steadily during the last 15 years of the 20th century and it can be said that Fiji is one of the countries with moderately low MMR in the region.

Trend in Maternal Mortality Ratio in selected countries



Source : WHO/ WPRO, Nov 2001.

(*) IMR =number of infants who die before the age of 1 per 1000 live births. CMR = number of children who die before the age of 5 per 1000 live births.

(+) MMR = maternal deaths per 100,000 live births.

The country is in the midst of rapid industrialization. The effects are not all positive. The country is facing problems associated with a **change in eating habits and life-styles** of men and women. Various nutritional deficiencies are found. A national nutrition survey in 1993 reported a prevalence of 7.1% underweight, 1.6% stunting and 8% wasting in children under 5.[9(*)] Nutritionally inadequate weaning foods, reduced feeding frequencies and poor sanitation seem to be contributing factors. There is some ethnic variation in incidence of these problems with underweight and wasting more prevalent in Indian children (13%) under 5 than Fijian (2.8%) children in the same age group.[10] Given the serious life-long implications of poor childhood nutrition,[11] **the Committee** might wish to investigate the degree to which this phenomenon reflects problems of discrimination either between the sexes or between ethnic communities (for example, discriminatory feeding patterns in infancy, food taboos etc.) varying life-styles, or other issues. The State party might also be encouraged to increase attention to availability of sex disaggregated data related to nutrition. Furthermore, existing nutrition programmes should be evaluated (effectiveness and coverage) to determine if changes are needed to assure equitable access to all population groups needing nutrition services.

Nutritional problems for women continue beyond childhood with iron deficiency anaemia a major problem affecting women of childbearing age. The same 1993 National Nutrition Survey previously referred to found 32% of women were anemic compared to 16% of men, with levels among pregnant women running above 50% for both Indian and Fijian women. 62% of Indian women and 52% of Fijian women were anemic. More recent surveys, although more limited in size suggest the problems continues. A 1995 survey of 300 pregnant women in 2 divisions of the country found 30% were mildly anemic, 35% moderately anemic, and 15% were severely anemic.[12] 1998 survey of female students aged 13-16 in one sub-region of the country found 33.8% to be anemic.[13] Without appropriate treatment these adolescents could enter pregnancy anemic with all the risks that brings to mother and the child she might bear. Investigation of this issue might explore issues such as women's knowledge about, access to and control of food resources or the income needed to buy food, and programmes could be developed to address those issues found to contribute to nutrition problems among women.

At the other end of the nutritional spectrum an increase in obesity and overweight is being observed as an emerging health problem, particularly among Fijian women. In the 1993 survey 25.2% of males and 29.9% of females were overweight while 7.4% of males and 20.6% of women were obese.[14] Sedentary lifestyles, reduction in physical activity together with increase intake of carbohydrates and fats seem to be the major contributing factors. Similarly, such factors contribute to the high prevalence of cardiovascular diseases, diabetes and cancers, the leading causes of female deaths in Fiji.

Mental health problems are apparent among the **young people** of Fiji. In 1998 it was reported that Fiji had the highest suicide rates in the world for both males and females aged 15-24[15]. A one year study of people attempting suicide and attending at the main general hospital in Fiji (15 January 1999 - 14 January 2000) found that of 39 people who attempted suicide 56.4% were young (aged 16-25) and 61.5% were female[16]. The **Committee** might wish to inquire about design and availability of services which can reach adolescents in gender sensitive ways in various settings -- in school, out of school, in the

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(*) **Underweight** = below minus two standard deviations from median weight for age of reference population. **Wasting** = below minus two standard deviations from median weight for heights of reference population. **Stunting** = below minus two standard deviations from median height for age of reference population. Source : Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). WHO and UNICEF.

work place etc. -- to help address in positive ways the factors leading to this unfortunate phenomenon.

There is a rise in **teenage pregnancies, unsafe abortion and sexually transmitted infections** among adolescents[17] all of which indicate the need for youth-friendly adolescent services, including but not limited to effective sexual and reproductive health services.[18] The government has initiated a programme to provide access to reproductive health information and services for adolescents in the capital city, Suva. The **Committee** might wish to encourage the government to monitor this programme carefully, particularly with reference to the gender balance in provision and utilization of services, and to consider ways and means to extend such services to young people in other parts of the country. In the presence of HIV/ AIDS such work is of particular urgency.

The Government is to be congratulated on their discussion of problems of **trafficking and prostitution**[19] in their present report. Their comments are reinforced by the work of the Special Rapporteur on the sale of children, child prostitution and child pornography who made a trip to Fiji (1999) and includes in her report discussion of the challenge presented by sex tourism targeting children in Fiji[20]. These issues have serious and life-long mental and physical health implications for the people of Fiji -- both women and men. The **Committee** might, therefore, wish to stress the importance of looking for new and effective ways to reduce the incidence of these problems and their impact on the health and security of the Country. Action might be encouraged on regional and local bases, in collaboration with both domestic and international authorities. In particular, training for both recognition of problems and appropriate action by immigration and law enforcement officials as well as health care providers.

Domestic violence against women and children appears to be a serious and increasing health problem. Police reports for the period 1994-1998 showed a total of 2,803 cases of domestic violence were reported. The last year of that period (1998) showed a 30% increase compared to 1997[21]. A study of the incidence and prevalence of domestic violence and sexual assault in Fiji found that most women neither seek medical attention nor report to policy. Perpetrators are mostly male family members. In the case of pregnant women drunkenness on the part of the male and refusal to have sex while pregnant on the part of the woman were given as the main reason for violence. The **Committee** might wish to pursue this issue. It is a blatant violation of the women's rights. Furthermore it has serious social and health consequences. An appropriate response needs to raise issues of law and law enforcement; empowerment and organization of women; health care and treatment for both the woman and perpetrator; training of teachers, police officials, and healthcare providers; education to eliminate gender bias and work towards greater social and personal equity between boys and girls, women and men.[22]

In this connection the **Committee** might wish to reinforce and elaborate on issues raised by the Committee on the Rights of the Child[23] relative to corporal punishment of children in the home and in school. In concluding remarks they comment on the urgency of taking action against child abuse and the importance of improving availability of rehabilitation services for abused children. In particular the CEDAW **Committee** might wish to emphasize the importance of disaggregation of data on such issues and development of appropriate mental, physical, and psychological services for both children and perpetrators, particularly in the case of family abuse.

As is true elsewhere, In Fiji, the poorest people tend to live in single-headed households, especially **female headed households** were women are either very young or elderly widows. They live in low-cost housing facilities provided by government or in squatter settlements and have minimal access to allowances from government. The difficulties

women face compared to men in finding work, in living with the very small income, and in dealing with various forms of discrimination they encounter make female-headed households particularly vulnerable. The UN sources report (1985-1990) 32 % of all households were women-headed[24]. It is noteworthy that the Government of Fiji, specifically the Ministry of Women, Culture, and Social Welfare has formulated a Women's Plan of Action with several objectives including mainstreaming of gender concerns in all aspects of development policy and programmes, for example, micro enterprise development, poverty alleviation, prevention of violence, among others[25]. Given the financial, social, and time constraints under which these women operate they often pay little or no attention to their own health and nutrition needs. The **Committee**, therefore, might wish to emphasize the importance of integration of health information and services as part of a comprehensive response (legal, economic, social, personal) to the needs of women heading households. Furthermore, The **Committee** might wish to recommend research and careful monitoring to know the scope of the problem and the social, economic or other patterns which lead to significant numbers of women being responsible for single-headed households.

It is regrettable that little information was found on **ageing and older women**. The **Committee** might wish to encourage specific research be carried out on the situation of older women, the degree to which they encounter discrimination, its impact in their lives, alternatives to respond to their priority needs and assure them a dignified life. Further research may also be needed relative to **other vulnerable groups** of women, for example migrant/ temporary workers and women with disabilities.

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1 UN (United Nations). *The World's Women 2000 : Trends and Statistics.* New York : UN 2000, p. 20.
2 Ibid.
3 WHO. *World Health Report 2001*, p. 138.
4 UNFPA, State of World Population. 2001. Table with Indicators for Less-Populous Countries/ Territories. Version of report on UNFPA Web site.
5 World Bank. *World Development Report 2000/ 2001.* p. 273.
6 WHO. Notes from WHO WPRO. Input to 26th session of the Committee on the Elimination of Discrimination. Nov 2001.
7 IMR = UNICEF. State of the World's Children 2000 (IMR) and 2001 (CMR).
8 WHO. Notes from WHO WPRO. Input to 26th session of the Committee on the Elimination of Discrimination. Nov 2001.
9 Saito, S. *1993 National Nutrition Survey. Main Report.* National Food and Nutrition Committee. January 1995. Sited in WHO/ WPRO notes. Input to 26th session of the Committee on the Elimination of Discrimination.
10 Ibid.
11 Childhood nutrition has influence throughout the life cycle. For example, malnutrition can contribute to poor mental and physical development in childhood. That malnourished child often becomes an adolescent or young adult woman who has difficulty with her pregnancy because of poorly formed bones or small structure. And later in life she may be particularly susceptible to osteoporosis.
12 Chand, M.J. *A Study of Factors Contributing to Anaemia in Pregnant Women and Pre-Schoolers in Fiji.* Ministry of Health, Suva. 1995.
13 Ministry of Health. *Ba Sub-division: Anaemia report.* Unpublished report. 1998.
14 Saito. Op. Cit.

[15] UNICEF. *State of Pacific Youth 1998.*
[16] Aghanwa, H.S. "The Characteristics of suicide attempters admitted to the main general hospital in Fiji". *J Psychosom Res.* 2000 Dec 49: 439-445.
[17] WHO/ WPRO notes. Input to 26th session of the Committee on the Elimination of Discrimination. Nov 2001.
[18] WHO/WPRO Op.Cit.
[19] See State Party Report. CEDAW/C/Fiji/1,6.1.
[20] Calcetas-Santos, Ofelia. *Rights of the Child. Report of the Special Rapporteur on the sale of children, child prostitution and child pornography on her mission to the Republic of Fiji on the issue of commercial sexual exploitation of children.* 11-16 October 199. UN Doc E/CN.4/2000/73/Add.3.
[21] WHO/ WPRO notes. Input to 26th session of the Committee on the Elimination of Discrimination. Nov 2001.
[22] WHO is presently working with local institutions in several countries on a multi-country study of domestic violence against women and its health impact. Should the State Party or any organizations in Fiji be interested in carrying out such research in Fiji various materials are available upon request from WHO.
[23] CRC. Fiji State Party Report. UN Doc CRC/C/28Add.7.
[24] UN (United Nations). *The World's Women 2000 : Trends and Statistics.* New York : UN 2000. p. 49.
[25] WHO. Notes from WHO WPRO. Input to 26th session of the Committee on the Elimination of Discrimination. Nov 2001.

Comments on the health of women in Estonia

Estonia is a small country in the northern part of Eastern Europe. In 2000, the total population was 1.4 million people with slightly more women than men (740,000 women and 656,000 men).[1] The country is heavily urbanized with 69% living in urban areas.[2] Economically, the country is placed in the upper middle income group.[3] The women of Estonia have a noticeably longer life expectancy than men (75 years for women, 63 for men).[4] By 2000 24% of women (only 15% of men) were over 60 years of age[5].

General levels of health as measured by **life expectancy, infant and child mortality**(*) have been improving noticeably. Life expectancy declined during the early 1990s but, by the end of the decade was improving.[6] As is common in many places, life expectancy for women exceeds that for men. However, the size of the gap, 12 years, is larger than usual. In the forty years 1960-1999 steady progress was made in reduction of both infant and child mortality rates, IMR declining from 40 per 1,000 per live birth in 1960 to 17.[7] Child mortality decline from 52 to 21 per 1,000 live births in the same period.[8]

	1960	1998-99
IMR	40	17
CMR	52	21

The State Party Report to the Committee on Economic, Social, and Cultural Rights (2001) indicates that in 1997 perinatal mortality in rural areas was higher than in towns because specialized assistance was less accessible than in urban areas. The **Committee** might wish to inquire what progress has been made in strengthening availability of a full range of health services needed by women in rural areas.

By 1999 the government had also achieved admirably high levels of **immunization** coverage[9], contributing positively to human development and the improvements in life expectancy.

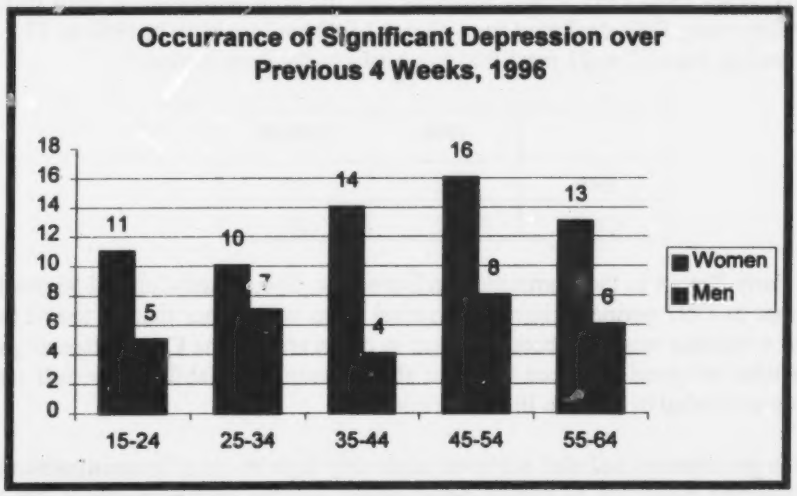
	TB	DPT	Polio	Measles
1997-1999	100%	94%	94%	89%

(*) **IMR** =number of infants who die before the age of 1 per 1000 live births. **CMR** = number of children who die before the age of 5 per 1000 live births.

On the other hand, in the field of **nutrition** some problems remained. For example, during the 5 years 1995-2000 malnutrition among children under 5 continued comparatively high: 17% were rated severely underweight, 16 % were suffering wasting; and 38% were stunted.(+)

Unlike many countries, **sex disaggregated data** in the health field is well developed in Estonia greatly facilitating analysis of health and identification of potential problems. Research carried out by various institutions in the late 1990s found that 48% of women and 43% men identified good health to be the most important aspects of life as compared with family relationships, material well-being, education and knowledge, and work achievements and recognition, travel opportunities, and comfortable life.[10] Women consistently **assessed their own health** to be "substantially worse than men's". On the other hand there has been improvement and the proportion of women who consider their health to be good or very good has increased to the extent that the difference between men and women has almost disappeared.

Indicators related to **mental health** found women consistently expressing more stress and/or measurable depression than men.[11]



(Source : Institute of Experimental and Clinical Medicine, 1996)

The **Committee** might want to investigate what is known about the causes of this phenomenon and the response to it by health and social service systems.

Life-style factors contributing to ill health, for example both smoking and consumption of alcohol are on the increase among both women and men.

Accompanying the socio-economic reforms of the 1990s, one sees a conspicuous change in social patterns including those related to **sexual behaviour and family formation**. The field of reproductive health is notable in Estonia for the "ever-earlier start of sexual activity"[12] Social relations are characterized by postponement of marriage and childbirth com-

(+) **Underweight** = below minus two standard deviations from median weight for age of reference population. **Wasting** = below minus two standard deviations from median weight for heights of reference population. **Stunting** = below minus two standard deviations from median height for age of reference population. Source : Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). WHO and UNICEF.

pared with the pre-1990 era, a decline in the proportion of registered marriages and marked increase in the popularity of cohabitation, a sharp increase in the percentage of children born out of wedlock, and a significant increase in the proportion of single-parent (usually mother) households.[13] For example, between 1980 and 1995 the share of births to unmarried mothers rose dramatically from 18% (1980) to 52% (1995)[14].

Abortion is legal and even in spite of an increase in the use of various methods of family planning and some decline in abortion, in the late 1990s abortion was still the main means of family planning and continued high relative to live births. For example, in 1997 there were 1.5 times more abortions than live births.[15] On the other hand, the maternal mortality ratio (MMR)(*) stands at 38.2, only slightly above the regional, European MMR of 37.[16]

These contemporary patterns clearly influence the nature and timing of women's need for gender sensitive, youth friendly health information and service including but not limited to sexual and reproductive health services. In this connection, the **Committee** might wish to discuss with the State Party the government response in law, public policy, health system development and health education to these changing realities. In particular, it would be important to raise the issue of the situation of the single-parent families headed by women and their access to the care and services needed both by themselves and their family members.

Analysis of health data on men and women in Estonia reveals an increase in cancer related problems with a worrying increase in cervical cancer among middle aged and younger women. There is also a steady increase in circulatory organ diseases amongst both men and women generally reputed to be related to lifestyles and the environment.

While data and analysis of health problems in Estonia appears well developed and stronger than many countries, development of more detailed information on **older women** -- their strengths, weaknesses, life styles, aspirations and so forth should be given priority attention. Global experience indicates this is a time of life health problems can multiply however, analysis and advance planning will ensure availability without discrimination of satisfactory services when needed. Particularly given the significant gap in male and female population (mentioned earlier) many of the older women will be without male partners and may have only limited social support networks. In this situation government attention to special needs of these women takes on extra importance. The **Committee** therefore may wish to raise this issue with the State Party.

Overall the picture of women's health and health problems shows progress in recent years. Furthermore, the availability of data disaggregated by sex and often by age is admirable. The government is to be congratulated in this regard. At the same time the **Committee** might wish to draw the attention of the State Party to the need for strong and accessible sexual and reproductive health services for adolescents and young adults and increased attention to the evolving needs of single mothers, older women and other vulnerable groups of women, for example migrant/ temporary workers and women with disabilities.

Although there is little easily available data on problems of trafficking and sexual exploitation in Estonia indications of its growing threat in some parts of Eastern Europe suggest it would be well for the State Party to encourage research in this area and adopt pro-active policies which would discourage such a pattern in Estonia.

(*) Maternal Mortality Ratio = maternal deaths per 100,000 live births

[1] UN (United Nations). *The World's Women 2000 : Trends and Statistics.* New York : UN 2000, p. 20.
[2] UNFPA. State of World Population : 2001. Version on the internet. Table on Demographic, Social, and Economic Indicators.
[3] The World Bank. *World Development Report 2000/2001.* Washington : World Bank p 273.
[4] UN (United Nations). *The World's Women 2000 : Trends and Statistics.* New York : UN 2000, p. 20.
[5] Ibid.
[6] Essay about health in Estonia ("Health of women and men in Estonia, 1990-1998) issued by Head, Health Promotion Office, Public Health Department of the Ministry of Health.
[7] UNICEF. State of the World's Children : 2001. p. 78.
[8] UNICEF. Op Cit. p. 107.
[9] UNICEF, Op. Cit. p. 86
[10] Reference by Health Promotion Office, Op. Cit., to work of the Estonian Institute of SocioEconomic Analysis (1994), Institute of Experimental and clinical Medicine (1996), the Estonian Centre for Health Education and Promotion (studies 1990 - 1998)
[11] Health Promotion Office. Op. Cit.
[12] Ibid.
[13] UNDP. Estonian Human Development Report : 2000. Internet version. p 42.
[14] Ibid. p. 47
[15] Health Promotion Office. Op. Cit.
[16] WHO website Information on Maternal Mortality. 1995 work of WHO, UNICEF, and UNFPA. Maternal Mortality Ratio for EURO region (WHO), 37.

Comments on the health of women in Trinidad and Tobago

Trinidad and Tobago is an island nation in the south eastern corner of the Caribbean with a total population of 1.3 million people (651,000 women and 644,000 men[1]). The population growth rate is very slow (0.6% per year[2]). The people are largely city dwellers (74%[3]).

Until very recently, women's health issues were addressed primarily in terms of women in their reproductive years (18-44).[4] Gradually increasing attention is now being paid to a broader range of women's health issues including problems of older women, an important development given female life expectancy of 76 years, (male life expectancy 72 years).[5]

The Government of Trinidad and Tobago is to be congratulated on the progress they have made reducing **infant mortality** (IMR)(*) going from 61 per 1,000 live births in 1960 to 17 in 1999[6].

There are various issues of importance related to the **health of adolescent girls** and the **Committee** might wish to seek some information in this regard : Information from a previous State Party report (1994)[7] indicated that there is a difference in the legal marriage age for boys and girls. Furthermore, the age level established for girls is set so low under all legal systems (14 under Hindu law and 12 under Muslim and common law) as to place the health of a girl at considerable risk and, should she become pregnant, also place her child at risk. Data on teen age pregnancy in Trinidad and Tobago indicates that while not all adolescent pregnancies are associated with high risk conditions, they are disproportionately linked to young mothers living in poverty and thus often associated with poor prenatal care and the birth of low birth weight babies.[8] The **Committee** might wish to inquire about developments in this regard, in particular progress in moving toward elimination of inappropriately young and sex differentiated legal age for marriage both of which place girls at great risk with reference to their health as well as socially, legally, and educationally. The **Committee** might also wish to explore whether or not there are challenges presented by the continuation of traditional practices in the community which are harmful to the health and well being of girls, women, and the children they may bear.

It should be noted that the incidence of sexually transmitted infections (including HIV) has been on the rise among adolescents in Trinidad and Tobago. **HIV**, itself, is a matter of considerable concern and has been for some time. The incidence of HIV/ AIDS among women aged 15 - 19 doubled between 1989 and 1990. By 1997, women accounted for 45% of all new cases. They also accounted for 33.7% of deaths from AIDS. At the same

(*) Infant Mortality = number of infants who die before age 1 per 1,000 live births.

time, by 1999, young people -- men and women -- between the ages of 15 and 24 accounted for 50% of all new infections, a reminder that adolescent girls are at particular risk. In light of the problem of teenage pregnancy (previously mentioned) it is important to keep in mind the risk of mother-to-child transmission (MTCT) of HIV and its high social, economic and other costs.[9] The **Committee** might, therefore, wish to inquire about public policy, law, and community level action to strengthen access of young people to appropriate services and their utilization in the context of a comprehensive approach to reduce the impact of HIV/ AIDS among the people of Trinidad and Tobago, including issues related to care of orphans. At the same time attention should be directed to equitable support and counselling for people with HIV, particularly HIV+ women, with an eye to prevention of mother to child transmission (MCTC).

The gender inequities -- social, economic, sexual decision making and so forth -- which place women at risk of HIV infection also place them at risk of gender based **violence and sexual abuse.** An increase in reported domestic violence is noted by the National Domestic Violence Hotline[10]. In the absence of good data it is not clear whether this reflects an increase in violence or an increase in reporting. In themselves, reports already indicate that violence must be an issue of concern : in 1998 84% of the calls were made by women while only 16% were made by men.[11] In 2000 24 murders were recorded as a result of domestic violence, 715 cases of beatings and 91 cases of incest.[12] It is well documented that violence against women, a phenomena with roots in firmly entrenched social inequities between women and men, has long and short term negative impact on a woman's health and well being. Nonetheless, detailed information is insufficient for effective analysis of the problem from the health perspective or development of possible solutions. The **Committee** might wish to ask for further information related to this issue -- for example marital rape, possible dowry abuse in some communities, or persistence of other traditional social/ cultural patterns which may contribute to perpetuation of domestic violence. The **Committee** might also wish to encourage the State Party to research the issue more fully[13] giving due consideration to the views of women and men in the community, public policy, education, law and law enforcement, among other aspects.

Information is also limited on women in the **older age bracket.** However, it is known that chronic, non-communicable conditions are responsible for the morbidity rate of women in Trinidad and Tobago contributing to 60% of women's disability cases in the 65+ age group. For example, medically diagnosed hypertension was reported by 50% of women who were over 65 years of age. Diabetes is now the second highest cause of death in women[14]. Given the growing per cent of the population that will be represented by women in this group, the **Committee** might wish to emphasize the importance of non discrimination by reason of age, sex, or any other characteristic and the importance of building up a government capacity to provide adequate, appropriate, and accessible health information, care and service including particularly for older women. Effective work in this direction would undoubtedly require a multifaceted programme including research as well as strengthening and diversifying information and service.

Evidence on the health of women in Trinidad and Tobago suggests that while there has been progress for some groups, there are still groups needing increased attention. It is to be regretted that more data is not easily available on **specially vulnerable groups** of women (for example the disabled, migrant workers, and sex workers) and efforts to improve response to their needs. Encouragement from the **Committee** for broad and equitable research and action in these areas could be beneficial.

[1] UN (United Nations). *The World's Women 2000 : Trends and Statistics.* New York : UN 2000, p. 19.
[2] WHO, *World Health Report 2001.* p. 142.
[3] UNFPA, State of World Population : 2001. Web version. Table on Demographic, Social and Economic Indicators.
[4] WHO/PAHO, note dated 21 Nov 2001. In put for 26th session of CEDAW Committee.
[5] UN (United Nations). *The World's Women 2000 : Trends and Statistics.* New York : UN 2000, p. 81.
[6] UNICEF. *State of the World's Children : 2001.* New York : UNICEF. p. 111.
[7] Initial Report of the Government of Trinidad and Tobago to the Committee on the Rights of the Child. UN Doc CRC/C/11/Add.10.
[8] WHO/PAHO. Op. Cit.
[9] Data on HIV/ AIDS from WHO/PAHO. Included in note dated 21 Nov 2001. In put for 26th session of CEDAW Committee.
[10] WHO/PAHO. Op. Cit.
[11] WHO/PAHO. Op. Cit.
[12] Official Report of the Modus Operandi of the Ministry of National Security, Trinidad and Tobago.
[13] WHO is presently working with local institutions in several countries on a multi-country study of domestic violence against women and its health impact. Should the State Party or any organizations in Fiji be interested in carrying out such research in Fiji various materials are available upon request from WHO.
[14] WHO/PAHO Op Cit.